No. 11180.

IN THE

United States Circuit Court of Appeals

FOR THE NINTH CIRCUIT

HARRY LUTZ and HARRY LUTZ and ROSE LUTZ, as executor and executrix of the last will and testament of Abe Lutz, Deceased,

Appellants,

vs.

NEW ENGLAND MUTUAL LIFE INSURANCE COMPANY OF BOSTON, a corporation,

Appellee.

APPELLANTS' OPENING BRIEF.

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Jurisdiction.

This is an appeal by the defendant Harry Lutz from a judgment of the United States District Court for the Southern District of California, Central Division [I, 62] declaring a policy of life insurance issued by plaintiff (Appellee) to be void [I, 60], and formally cancelling and rescinding the policy [I, 62].

This appeal presents no question of jurisdiction of either this or the trial court. Appellee is a Massachusetts corporation; defendant is a resident of the County of Los Angeles, State of California, and the amount in controversy

exceeds the sum of $3,000.00, exclusive of interest and costs. The suit was brought by appellee under Section 41, U. S. C. A. (Judicial Code, section 24, amended).

Appellant filed an answer and counterclaim to which answer was interposed by Appellee. The case was tried before Judge Ralph E. Jenney, now deceased, whose opinion was rendered on May 4, 1945 [I, 352], and the judgment appealed from was entered on June 14, 1945 [I, 62]. The notice of appeal was filed on August 28, 1945 [I, 66].

Statement of the Case.

On December 1, 1942 [II, 384], upon the written application of the Appellant, the Appellee Insurance Company issued, and on or about December 9, 1942 [II, 384], delivered its policy of life insurance No. 1,172,844 on the life of another, to-wit, Appellant's 64 year old father, Abe Lutz, who is referred to in the policy as the "insured," insuring the life of the *assured's* (Appellant's) said father for the policy face amount of $13,000 and naming the *assured* Appellant, "applicant" therefor, the "beneficiary" and "the sole owner" of the policy which was made effective, and antedated, as of October 13, 1942.

By this appeal, Appellant seeks a review of the judgment in favor of the Appellee insurer on its complaint filed after the death of the "insured," for cancellation and rescission of the policy, notice of which was also given after the loss occurred. The Appellee insurer's complaint, as amended, alleged [I, 2], that the trial court found [I, 49], the policy void and formally cancelled and rescinded [I, 62] the same on the premise that the "insured" misrepresented and concealed facts concerning his health and

medical history which were material to the risk insured against; that the Appellee relied thereon and was misled to its prejudice thereby, and that the "insured" was not in that state of health prerequisite to the policy's validity when the application therefor was approved and the first premium thereon was paid.

There is no claim or allegation in said complaint, no evidence offered to support and no finding made that the *assured* Appellant, the "applicant" for, "beneficiary" and "sole owner" of the policy, was a party to such, or any, alleged concealment or misrepresentation.

On November 14, 1942, Appellant, as the "applicant for insurance," and his now deceased father, Abe Lutz, as the consenting "proposed insured," signed the application which is identified as "Part I" and which contained no part of the alleged concealment or misrepresentations upon which said complaint, findings and judgment are premised. Appellant signed no other application or document other than said "Part I" [II, 405].

Two days later, on November 16, 1942, Appellant's 64 year old father submitted himself to a physical examination by Appellee's medical examiner [Finding V] who thereafter made his report to Appellee company [Ex. 27, II, 408a]. Appellant's said father orally answered the printed questions with respect to his medical history in the separate document entitled "Part II" [II, 406] as said medical examiner propounded *his interpretation of them* to Appellant's said parent, and, after said medical examiner in his own longhand wrote *his interpretation of the answers* thereto of the "insured," in the blanks, after the printed questions. Appellant's father *alone* signed said

"Part II" at the bottom thereof above a provision therein whereby Appellant's father did

> "* * * expressly waive * * * all provisions of law forbidding any physician or other person who has attended or examined me, or who may hereafter attend or examine me, from disclosing any knowledge or information which he thereby acquired, and I authorize any such disclosure." [Ex. 27, II, 406.]

Said waiver of and authorization for such full disclosure executed by Appellant's father is hereinafter referred to as the "insured's waiver of privilege and authorization for full disclosure."

Before the "insured" signed "Part II," the medical examiner wrote therein as the answer of Appellant's father to

Question 28: that the "insured" had been declined for insurance a few years before by Equitable Life;

Question 37: that the "insured" had been suspected of having sugar or albumen in his urine;

Question 32: that the insured's weight had decreased about 15 pounds in the last two years;

Question 33: that the insured's present weight had been maintained only about 3 months;

Question 36: that the "insured" had consulted and been physically examined by Dr. Maurice H. Rosenfeld of 1908 Wilshire Boulevard during the then preceding August, 1942.

At the same time, on November 16, 1942, when the "insured" and the only signer of "Part II," affixed his signature to "Part II" below the "insured's waiver of

privilege and authorization for full disclosure," the medical examiner knew that:

(a) During the physical examination referred to in "Question 36," *supra,* Dr. Maurice H. Rosenfeld checked the insured's heart [I, 218];

(b) the "insured" had a history of diabetes [I, 216];

(c) the "insured" had been rejected for insurance on account of sugar in his urine [I, 216];

(d) he, the medical examiner, had examined the "insured" several times before [I, 216].

On November 27, 1942, three days before the policy in suit was issued and 12 days before its delivery, Appellee was advised on receipt of a letter from the medical director of the Equitable Life Assurance Society [Ex. 27, II, 411-412] that:

(a) the "insured," in addition to Dr. Maurice H. Rosenfeld named by the "insured" in "Part II," had also been attended by Dr. Lissner who was not named or mentioned by the "insured" in said "Part II";

(b) Equitable refused to issue additional insurance on the life of the "insured" [Ex. 27, II. 412].

When the policy in suit was issued [II, 384] and over one week before it was delivered [II, 384], the Appellee knew that it did not have, was on notice and inquiry [II, 432] of Messrs. Hays & Bradstreet at 609 South Grand Avenue, Los Angeles, California, Appellee's "general agents" [I, 271], to secure:

(a) "a complete detailed statement from Dr. Rosenfeld and Dr. Lisner";

(b) "full details" with respect to:

1. "why were the doctors consulted"?
2. "what were the symptoms"?

3. "what were the findings"?
4. "what treatment or advice was given"?
5. "what were the results"? [Ex. D; II. 432].

Pursuant to Appellee's inquiry [Ex. D; II, 432] to its "general agents" [I, 271] in Los Angeles for "full details" with respect to "why" Doctors Rosenfeld and Lissner were consulted, what treatment or advice was given and what the symptoms, findings and results were, Mr. Harold Morgan, the brokerage manager [I, 310] of Appellee's said general agents, did not talk to Dr. Rosenfeld [I, 147] and it appears that he may have satisfied himself by merely talking to Dr. Rosenfeld's bookkeeper on the telephone inasmuch as Mr. Morgan in his own longhand [I, 328-330] wrote on Appellee's letter [Ex. D; II, 432] of inquiry the following:

"EX 1369"

which was Dr. Rosenfeld's telephone number [I, 146];

"Miss Byington"

which was Dr. Rosenfeld's bookkeeper [I, 146];

"Because of requirements of Equitable for B. L. S. U."

which referred to blood sugar [I, 329] in response to the inquiry as to why the doctors were consulted;

"None"

[I, 329; II, 432] opposite: what were the symptoms;

"Neg"

[I, 330; II, 432] opposite: what were the findings;

"None"

[I, 330; II, 432] opposite: what treatment or advice was given; and

"Satisfactory"

[I, 330; II, 432] opposite: what were the results.

Automatically, as a custom, usage and routine, Appellee's "general agents" request a retail credit inspection on applications which are submitted to Appellee [I, 343], but in this instance the services of the Retail Credit Company's insurance inspector and investigator, Mr. Paul M. Arnold, were not employed by Appellee until the last week in June, 1944 [I, 238], approximately 30 days after Appellant's father died (May 28, 1944). The investigator, Mr. Brown, as the first step in his investigation, contacted Dr. Rosenfeld [I, 239] who answered all questions with respect to the "insured's" health and condition [I, 240].

Appellee is a member of the Medical Information Bureau of Cambridge, Massachusetts [I, 283], also known as "MIB" [I, 299], and during the months of November or December, 1942, obtained therefrom information "in code" [I, 283] concerning the "insured" which Appellee destroyed and was unable to produce at the time of trial [I, 284]. In January and March, 1943, and prior to the death of the "insured," Appellee received two other M.I.B. "confidential reports" with respect to the deceased [I, 298] which were not produced in court but which contained "confidential" information of such character as to cause Appellee "to refuse to proceed further" with the additional insurance [I, 298] requested concurrently [Ex. D; II, 426] with the application upon which the policy in suit was issued.

Before Appellee issued the policy in suit it made no investigation of the "insured's" previous insurance record [I, 286]. The reasons which prompted Appellee to *take a chance* without complete investigation, and issue the policy, notwithstanding the fact that Appellee was put

on notice and active inquiry [II, 432] of its "general agents" in Los Angeles [I, 271], is explained frankly, as a "risk" [I, 293] consciously taken and embraced by Appellee where the face amount of the policy is "under $15,000" to avoid "expense" and "delay in issuing policies" [I, 293], by Appellee's medical director [I, 247], Harold M. Frost, M.D. [I, 246], who approved [I, 255] the application for the policy in suit, as follows:

> "The reason for requesting detailed statements from Doctors Rosenfeld and Lissner arises from the fact that Medical Directors have learned from unfortunate experience that the statements of applicants as to their consultations with physicians must be evaluated with caution. Medical Directors are convinced that the average individual intends to be honest. However, we have learned that some applicants apparently attempt to conceal damaging information; that others have not understood the information as to their condition given them by their physicians and therefore have not considered it significant; that others have actually not been advised by their physicians as to the significance of serious signs or symptoms which the physician had discovered. Not infrequently a statement from the physician will prove that what appeared an insignificant consultation, from the information given by the applicant in his answers to questions in Part II of his application, was actually a serious matter, the physician having discovered signs and symptoms which would forbid issuance of life insurance at standard rates and might necessitate its issuance at substandard rates, or might necessitate rejection of the risk.

"As a practical procedure, considerations of expense in obtaining such statements, for which the physicians must be paid by the company, and the delay in issuing policies as a consequence of requesting such statements influence the Medical Director in formulating his policy as to how frequently and in what types of cases a physician's statement will be required.

"In the case of applications for large amounts of insurance, a routine requesting of physician's statements is necessary for the protection of the company as large amounts are at risk. As for small applications, amounts under $15,000, within which range the great majority of applications fall, the routine requests are neither practical nor feasible because of excessive expense and undue delay in issuing policies.

"The only practical policy as respects applications for small amounts of insurance is to request physicians' statements only when the applicant in his statements as to his medical history raises definite doubt as to his insurability. Further, it is common knowledge among medical directors that applicants at the older insurance ages, the late fifties and the sixties, must be scrutinized much more carefully as to medical history and condition of health than in the case of applicants of younger ages. Companies generally do not issue to older applicants as much insurance as to younger applicants, because in general the older applicants are not as good physical ratings as the younger applicants.

"In the case of Mr. Lutz, when I reviewed his application I noted that he was in his sixty-fifth year,

a definitely advanced insurance age. He applied for $13,000 of insurance. At the same time a request was made for an additional $13,000 of insurance. For a man as old as Mr. Lutz, $13,000 of insurance would be considered only a moderate amount to be issued by a company the size of the New England Mutual Life Insurance Company, while $26,000 of insurance would be considered a large amount to be retained by such a company.

"As I had no reason to doubt the accuracy of the statements of Mr. Lutz as to his medical history, I, depending upon his honesty, believed that I could safely approve his application for $13,000 of insurance without asking for statements from Doctors Rosenfeld and Lissner. His physical examination was satisfactory, and I had no other information of an unfavorable nature as respects his medical history or health. I therefore approved his application for $13,000.

"I believed, however, that, in view of his advanced insurance age, that for his age the amount of $26,000 life insurance was a large amount to be issued by my company, and the fact that he had admitted consulting Dr. Rosenfeld, and to my knowledge had consulted Dr. Lissner, that it would be advisable to request the detailed statement as recited in [Ex. D; II, 432], whereupon this statement was requested." [I, 292-295.]

Appellant in his application ("Part I"), agreed that "this application, including Part II, a copy of which shall be attached to the Policy when issued, shall become a part

of every Policy issued hereon" [Ex. 27; II, 405]. The policy in suit provides that said "Part I" and "Part II," which includes the "insured's waiver of privilege and authorization for full disclosure," are incorporated in and expressly made a part of the insurance contract [Ex. 3].

The policy was delivered to Appellant [Finding VI], "the sole owner" [Ex. 3] and "beneficiary" appointed "without right of revocation by the insured" [Ex. 3]. Appellant paid Appellee all premiums required to be paid [Finding XX and XXV] *i. e.,* two annual payments.

The "insured" died May 28, 1944 [Finding VIII], one year, 7 months and 15 days after the effective date of the policy, and the Appellee filed its original complaint on October 11, 1944, and the amended complaint [I, 2], which added paragraph XVI [I, 14-15] thereof (alleging that at the date of Appellee's approval of the application, and issuance of the policy in suit and receipt of the payment of the first premium thereon, Appellant's father (the "insured") was suffering from heart trouble, dizziness, fainting spells, palpitation of the heart, shortness of breath, pain and pressure in the chest, nausea, indigestion, and various other ailments), was filed January 31, 1945 [I, 21] *i. e.,* over two years after date [Ex. 3], issuance [Ex. 1; II, 384] and delivery [Ex. 1; II, 384] of the policy [Ex. 3] which was incontestable after it had "been in force for a period of two years from its date of issue." [Ex. 3].

Specification of Errors.

Appellant's concise statement of points on appeal is printed in the appendix hereto. Summarized, the errors relied upon in this appeal are that:

(1) The trial court erred in denying Appellant's motion to dismiss [I, 195];

(2) The trial court erred in admitting, over Appellant's objection, testimony of the insured's attending physician relating to the health and physical condition of the insured [I, 99-100];

(3) The trial court erred in decreeing rescission and cancellation of the policy for concealment and fraud, attributed to the "insured", with respect to his health and medical history [I, 60-63];

(4) The trial court erred in failing to find that Appellee:

(a) Waived its right:

(1) To complain of concealment or fraud;

(2) To claim the insured was not in good health when the policy was delivered;

(b) Was estopped:

(1) To deny liability on the ground of fraud or concealment;

(2) To claim that the "insured" was not in good health when the policy was delivered.

(5) The trial court erred in

Finding V; in finding that:

(1) Appellee's medical examiner accurately recorded:

(a) the insured's answers to questions contained in "Part I" or "Part II";

(b) the insured's answers to Appellee's medical examiner's interpretation of said questions;

(2) The insured's answers were a part of said application, *i. e.,* "Part I";

(3) The insured read said application [I, 50-51; Finding V].

Finding IX; in finding that:

(1) The insured in "said application" ("Part I") or in "Part II" represented to Appellee that the insured had "never" suffered from indigestion, dizziness or fainting spells, palpitation of the heart, or pain or pressure in the chest;

(2) The insured *ever* suffered from "indigestion", "fainting spells", or "pain in the chest" [I, 52; Finding IX].

Finding XI; in finding that:

(1) The insured, within 5 years prior to the date of either "Part I" or "Part II", had consulted or been treated "by physicians for dizziness or fainting spells";

(2) The insured had ever been told unequivocally that he was suffering from angina pectoris;

(3) The insured's physician ever prescribed medicine to relieve pain in the "chest";

(4) The insured ever suffered pain in the "chest" for any cause or reason whatsoever;

(5) The matters in subdivisions (1), (2), (3) and (4) immediately above mentioned were concealed or undisclosed in "Part II" [I, 52-53; Finding XI].

Finding XII; in finding that:

The matters found in Findings IX and XI with respect to which it is hereinabove urged that the court erred, were known to the insured when he signed "Part II" [I, 53; Finding XII].

Finding XIV; in finding that:

The insured had knowledge of the terms or provisions of the policy in suit [I, 54; Finding XIV].

Finding XV; in finding that:

Prior to the insured's death, Appellee had no knowledge, information or notice that the insured had failed to disclose the fact that he had theretofore consulted or been examined by physicians other than Dr. Rosenfeld [I, 54; Finding XV].

Finding XIX; in finding that:

(1) Said insured was not in good health at the time said policy was delivered, or the first premium thereon was paid;

(2) Said insured knew he was not in good health or was suffering from angina pectoris at the time said application was signed or delivered or at the time said policy was issued or delivered, or at the time the first premium thereon was paid [I, 56; Finding XIX].

Finding XXI; in finding that:

(1) At the time "Part I" or "Part II" was signed, said insured knew:

(a) the contents thereof;

(b) the answers to the questions therein contained concerning the insured's health or medical history were not true;

(c) matters of fact concerning the insured's health or medical history were concealed or misrepresented in or by "Part I" or "Part II";

(2) The insured did not correctly or truly answer all or any questions asked him by the Appellee's medical examiner or by Appellee's agent who filled in the application [I, 57; Finding XXI].

Finding XXII; in finding that:

(1) Said insured did not furnish Appellee's agents or representatives with true or correct information

on all or any matters as to which information was requested by said agents or representatives;

(2) Said insured did misrepresent or conceal matters of fact concerning which the insured was interrogated [I, 57; Finding XXII].

Finding XXIII; in finding that:

(1) Appellee, or its representatives who contacted the office of the insured's physician, did not have the opportunity of obtaining full, true or correct information from such physician regarding the physical condition or health of said insured;

(2) Appellee did not have ample opportunity to ascertain the true facts concerning the health or medical history of said insured prior to the death of said insured;

(3) Appellee is not estopped to rescind or cancel said policy or to refuse payment of the proceeds thereof;

(4) Appellee is not precluded from relief by reason of its delay;

(5) Appellee rescinded said policy promptly upon discovery of the facts which it now claims were concealed from it [I, 57-58; Finding XXIII].

Finding XXIV; in finding that:

(1) Appellee did not have the opportunity of obtaining any information from the physician of the insured regarding the latter's physical condition or health;

(2) At the time of signing "Part II," the insured did not inform Appellee's medical examiner that Dr. Maurice H. Rosenfeld had given the insured a complete physical examination [I, 58-59; Finding XXIV].

(6) The trial court erred in its

Conclusion I, that: Appellee is entitled to judgment cancelling and rescinding the policy and

declaring it void, and requiring that the original be delivered to Appellee for cancellation [I, 60; Conclusion I].

Conclusion II, that: Appellee is entitled to judgment declaring that Appellant has no rights and Appellee has no duties, liabilities or obligations under the policy except that Appellant is entitled to recover from Appellee only $2,-523.43 as restoration to him of all premiums and considerations by him paid to Appellee [I, 60; Conclusion II].

Conclusion III, that: The policy failed to become effective because the insured was not and knew he was not in good health when the application was approved, the first premium paid and the policy delivered [I, 60; Conclusion III].

Conclusion IV, that: Appellee promptly rescinded and was entitled to rescind the policy by reason of misrepresentation or concealment of facts, known to the insured or material to the risk, which the insured ought to have communicated or disclosed in the application [I, 61; Conclusion IV].

Conclusion V, that: Appellee has not waived and is not estopped to assert its right to rescind the policy [I, 61; Conclusion V].

Conclusion VI, that: The matters alleged in Appellee's amendment to its original complaint (Paragraph XVI of the Amended Complaint) is not barred by the incontestable clause in the policy [I, 61; Conclusion VI].

Conclusion VII, that: Appellant take nothing by his counterclaim filed herein [I, 61; Conclusion VII].

ARGUMENT.

Summary.

POINT I.

The Appellee Insurer Cannot Repudiate the Policy, Deny All Liability Thereunder, and at the Same Time be Permitted to Stand on, Exercise Rights Under, and be Permitted to Enjoy the Benefits of a Provision Inserted in the Policy for Its Benefit.

It is Appellant's position: that after the "insured's waiver of privilege and authorization for full disclosure," contained in the document known as "Part II," was merged into and by the terms of the policy itself was expressly made a part thereof, the Appellee insurer's *subsequent* exercise of its power to elicit testimony from the "insured's" attending physicians (disclosing upon the trial of this case, over Appellant's objection, information relating to the medical history, health and physical condition of the "insured") was an exercise of a right accruing to Appellee under the policy or contract of insurance, the exercise of which was inconsistent with Appellee's position that the contract of insurance, the policy, was void; That Appellee cannot repudiate the policy, declare it void, and support its prayer for cancellation and rescission of the insurance contract, by standing on a provision in that contract empowering it to elicit from the deceased "insured's" attending physicians privileged communications acquired by them to enable them to prescribe

treatment for the "insured." This subject matter is treated in the argument under the following headings:

(a) The Parties to the Insurance Contract;

(b) The Policy, Including "Part I" and "Part II," Does Not Provide, Either Expressly or by Implication, That Appellant's Rights Are Predicated Upon the Conduct of the "Insured";

(c) Neither Appellant Nor the Heirs or Personal Representatives of the Deceased "Insured" Could Waive the Latter's Privilege With Respect to Confidential Communications to His Attending Physicians to Enable Them to Prescribe Treatment for Him;

(d) After the Policy Was Issued, the "Insured's" Waiver of Privilege Was an Integral Part of and Provision in the Policy for the Appellee's Benefit, and Its Rights and Powers Thereunder May Not Be Exercised and Enjoyed by It Concurrently With Its Affirmative Repudiation of and Prayer for Cancellation and Rescission of the Contract in Its Entirety;

(e) The Trial Court Erred in Admitting the Testimony of the Deceased "Insured's" Attending Physicians Over Appellant's Objections. In the Absence of Such Testimony, There Is No Evidence in Support of the Judgment.

POINT II.

The Appellee Is Precluded by Waiver and Estoppel.

It is Appellant's position: that his father, the "insured," gave true and correct answers to Appellant's medical examiner; that any erroneous answers, all written by and in the long hand of Appellee's medical examiner, to the printed questions in "Part II," were the result of and occasioned by said medical examiner's misapprehension of either the printed question in "Part II," or the answer thereto made by the *illiterate* "insured"; that the "insured's" vindication of fraud, misrepresentation, concealment and intention thereof, is established beyond cavil by his having given Appellee, in "Part II," the name and address of his attending physician, Dr. Maurice H. Rosenfeld, waived all privilege and affirmatively authorized all physicians or other persons who had attended or examined him to fully disclose to Appellee all knowledge and information, including the information which, after the "insured's" death, Appellee did secure, and proved in open court as the only evidence which appellee had or produced in support of the allegations in its complaint herein; that Appellee waived its right to the information which it claims was concealed from it, and is estopped to assert that it was misled or defrauded, inasmuch as Appellee was given the name and address of the attending physician of the insured and authority to elicit a full disclosure from said physician of precisely the same facts which after the death of the "insured" were introduced in evidence through the testimony of said attending physician

in support of Appellee's action to declare the policy void, and inasmuch as Appellee did get in touch with the office of said physician through its local general agent, and thereafter waited until it had received two annual premiums from Appellant and thereafter waited until Appellant's father, the "insured," died before it elected to and did communicate with said physician, from whom Appellee then readily elicited a complete and full disclosure. This is disclosed under the headings:

(f) All Answers to the Printed Questions in Part II of the Application Are Written by and in the Longhand of the Medical Examiner and Represent His Interpretation of That Which He Considered the Material Portion of the Insured's Answers to the Medical Examiner's, in One Instance, At Least, Admittedly Erroneous, Interpretation of the Printed Questions.

(g) The Appellee Had Placed At Its Disposal the "Exact Source" of Information From Which It Could Have Obtained Full and Complete Information on Everything It Now Claims Was Withheld From, and Misrepresented to, It.

(h) There Was No Fraud or Concealment.

POINT III.

Insured in Possession of Requisite Good Health.

It is Appellant's position that there is no competent evidence with respect to the state of health of the "insured" when the application was approved, the policy was delivered, or when the first premium thereon was paid; and that the burden of proving that the "insured" was not in that state of health prerequisite to the validity of the insurance contract is upon the Appellee as the insurer. This is discussed under the following heading:

(i) Appellee Has Not Sustained the Burden of Proof, and There Is No Competent Evidence, With Respect to Any Unfavorable State of the Insured's Health When the Application Was Approved or When the First Premium Was Paid or When the Policy Was Delivered.

(a) The Parties to the Insurance Contract.

The insurance contract and policy in suit is not a contract with the "insured" therein named, as is usually and ordinarily the case. The policy was *about* the "insured," but not *with* him; it is a contract between Appellee, as the insurer, and Appellant as "applicant" [II, 405] for "beneficiary" [II, 405], and "the sole owner" [I, 39] of the policy the person to whom the policy was delivered [Finding VI] and by whom all (two annual) premiums were paid [Finding XXV].

Appellant's father, the now deceased "insured" merely *consented* that his life might be the subject matter of a

life insurance contract between Appellee, as the "insurer," and Appellant. The "insured" did *not* sign the application as "the applicant" therefor; he signed "Part I" (the application) merely as the "proposed insured" [II, 405]. Appellant signed *only* "Part I" and as the "applicant for insurance" [II, 405].

The Appellant, and not the "insured," is a party, other than appellee, to the insurance contract here involved. The policy on its face purports to be and is made with Appellant. It was procured and paid for by and delivered to Appellant as "the sole owner" [I, 39] thereof. The "insured" had no rights under the policy. Appellant was the *assured* and was the only party to the contract, other than Appellee, who had any rights therein or thereunder.

Connecticut Mutual Life Ins. Co. v. Luchs (1883), 108 U. S. 498; 27 L. Ed. 800; 2 Sup. Ct. 949;

Brockway v. Connecticut Mutual Life Ins. Co. (1887), 29 Fed. 766;

Worrell v. Life & Casualty Ins. Co. (La. 1937), 172 So. 788, reaffirmed in 175 So. 434;

Millard v. Brayton (Mass. 1901), 59 N. E. 436;

Cyrenius v. Mutual Life Ins. Co. (N. Y. 1895), 40 N. E. 225;

Whitehead v. N. Y. Life Ins. Co. (N. Y. 1886), 6 N. E. 267;

44 *C. J. S.* 997, Sec. 238, Note 47.

In the *Whitehead* case, *supra,* where each of three policies on the life of the husband recited that the consideration was paid by the wife, and the money was to be paid to her, the court said:

> "These contracts purport upon their face to be contracts with the wife as the party assured, and not

at all with the husband, who stands in the policy as simply the life insured; his conduct and death furnishing the contingencies upon which the liability of the insurer is made to depend. As was tersely expressed in the argument, the contract was about the husband, and not with him."

In the *Cyrenius* case, *supra,* the court said:

"The fact that the father signed the application with the son is not a circumstance of much significance as against the language of the policy itself. The defendant, before entering into the contract, needed to be informed in regard to the age, health and general history of the person whose life was the subject of the risk. No one could furnish that but himself. This was the main purpose of the father's signature to the application. * * * The contract having been made with George in his own name for his own benefit, he alone * * * is entitled to sue upon or enforce the defendant's promise."

The "insured" signed Part I (the application) as the "Proposed Insured," thereby *consenting* that his life might be the "subject of the risk" in a life insurance contract between Appellee and Appellant. The contract purports on its face to be and it is made with Appellant as the party assured, and not at all with the "insured" who stands in the policy as simply the life insured, the "insured's" death furnishing the contingency upon which the liability of the Appellee insurer is made to depend.

The Appellee was in the business and wanted to write and the Appellant wanted to buy the policy in suit, and it may be said that the insured's *consent* that his life be the subject of the risk, evidenced by his signing "Part I," was equally for the benefit of both of the contracting parties, *i. e.,* Appellant and Appellee. However, even if it be

arbitrarily assumed that the insured's signing of "Part I" were for the benefit of Appellant, the fact remains that there is no fraud, concealment or misrepresentation contained in "Part I."

Whether "Part I" was signed for the benefit of both of the contracting principals, Appellee and Appellant, or only for the benefit of Appellant, the fact remains that "Part II," the "insured's" medical history and authorization for full disclosure to Appellee of all information acquired by his attending physicians, including Dr. Rosenfeld, was, if not equally for the benefit of both, for the *sole* benefit of Appellee. It surely was *not* contemplated that the "insured's" medical history and waiver of privilege and express authorization for the revelation of privileged communications to Appellee by the "insured's" attending physician, Dr. Rosenfeld, was included in the *application,* as such, for Appellant's benefit.

Before Parts I and II became a part of the contract by the issuance of the policy, "Part I" thereof was an offer (in which the "insured's" prerequisite *consent* thereto was included) by Appellant to enter into a contract. Two days later, the "insured" *alone* submitted to a physical examination, gave his medical history and signed "Part II" including the waiver of privilege and express authorization for the revelation of privileged communications to Appellee .

The "Insured's" waiver of privilege was included in the application, *as such,* for a purpose in connection with the *application,* as such, and not solely that it might become a part of the contract when the policy, of which it was contemplated that it would become a part, was issued, to the end that it would be used only to defeat liability on the policy after the loss occurred.

(b) The Policy, Including "Part I" and "Part II" Does Not Provide, Either Expressly or by Implication, That Appellant's Rights Are Predicated Upon the Conduct of the "Insured."

Appellant's application for insurance on the life of his father, the now deceased "insured," is "Part I" [II, 405]. Appellant did not sign "Part II" [II, 406]. "Part II" bears the "signature of the person examined," *i. e.,* the "insured," who signed the same two days after he, as the "proposed insured," and Appellant, as the "applicant for insurance" signed "Part I."

While Appellant, as "applicant for insurance," in his application ("Part I"), agreed that it, "including Part II" should be attached to the policy when issued and become a part thereof, nevertheless, Appellant did not underwrite the accuracy of, or endorse or give any warranty as to the truthful character of, the representations contained in "Part II."

The contract in suit provides that it, the policy, "Part I" and "Part II" are merged and "constitute the entire contract between the parties." Thus, the application, as such, became *functus officio* when the policy was issued, and thereupon became a part of the contract.

> While the policy provides (emphasis added) that "all statements made by the *Insured* or in his behalf, in the absence of fraud, shall be deemed representations and not warranties;"

and further provides that

> "no such statement shall be used in defense to a claim unless contained in the application and unless a copy of such application is attached to" the policy when issued,

nevertheless, the converse of the latter provision is not stated and does not appear, viz.: the policy *does not provide* that such statements *may be used* in defense to a claim in such a case as this where the "insured" is not a principal contracting party and the contract is between the *insurer* and the *beneficiary*. The "insured" in the instant case *had no rights* under the policy and signed "Part II" only to waive rights and not to acquire any.

With respect to the provision

> "* * * All statements made by the insured or on his behalf, in the absence of fraud, shall be deemed representations and not warranties; * * *" [Ex. 3].

it is pertinent to note that, inasmuch as the "insured" was not a principal contracting party, no statements were made, and nothing was said or done, "in his behalf"; and any fraudulent statement made by or attributed to him (which by reason of its fraudulent, actual or assigned, character would be declared a warranty rather than a representation under the above quoted provision of the policy), would merely constitute and be a warranty by one who, having no rights under the policy could forfeit no rights thereunder.

If the "insured" had been the "applicant" for the policy and thus one of the principal contracting parties, any fraudulent statement made by him in *his* application, "Part I" or in *his* medical history, "Part II," would have vitiated the contract as a *matter of law* for a breach of warranty

as defined by the above quoted excerpt from the policy. The above quoted excerpt only defines the circumstance under which a statement or representation will become a warranty. The law, not the policy in suit, determines the legal consequences that flow from a breach of warranty made by one of the contracting parties. Fraud of the "insured" or a breach of warranty by him, *had he been one of the principal contracting parties,* would have vitiated the contract *as a matter of law* without any contract to that effect and there is no contract to that effect in the case at bar; that is *implied in law* in every contract as between the contracting parties.

In the instant case, as in all cases, if the fraud of, or a breach of warranty by, a third party (the "insured" in the case at bar), who is not one of the principal contracting parties, is to invalidate the contract, the policy by its own terms must expressly so provide inasmuch as such a provision is *not* implied in law and the contract of insurance is, under well recognized principles of law, to be liberally construed in favor of the *assured* and strictly construed against the insurer.

While the policy also provides that it is issued, among other things, "in consideration of the application" (even though the word "application" be erroneously construed to include "Part II" as well as "Part I"), nevertheless, it does not provide that the policy is issued in consideration of the "applicant's," *i. e.,* Appellant's statement or warranty that the statements or warranties of the "insured" in "Part II" are true or correct.

Appellant is not a third party beneficiary, and he relies on no contract made by the "insured." Appellant relies on his own contract with Appellee under which the "insured" waived certain rights but acquired none.

The law provides that a breach of warranty by one of the contracting parties entitles the other to rescind. The law does not provide that a breach of warranty by a third person (the "insured") will entitle either of the contracting principals to rescind in the absence of a contractual provision to that effect.

(c) Neither Appellant Nor the Heirs or Personal Representatives of the Deceased "Insured" Could Waive the Latter's Privilege With Respect to Confidential Communications to His Attending Physicians.

Appellant did sign limited waivers after his father's the "insured's," death, while Appellee was investigating the claim. These waivers, however, were limited and for the purpose of adjustment and settlement of the claim, and were legally insufficient under California law to overcome Appellant's objection *upon the trial* to the admission of privileged communications between the deceased "insured" and his attending physicians.

Aetna Life Ins. Co. v. McAdoo, 106 Fed. (2d) 18.

Under the law in California, the heirs of the patient cannot waive the privilege.

Estate of Flint (1893), 100 Cal. 391.

Under the law in California, personal representatives of the patient cannot waive the privilege.

> *Harrison v. Sutter Street Ry. Co.* (1897), 116 Cal. 156.

While the *Harrison* case, *supra,* was decided before California Code of Civil Procedure, Section 1881, was amended to provide that the institution of an action for wrongful death constitutes a waiver, nevertheless, the case is directly in point here and the amendment mentioned does not change the law in the situation here before the court inasmuch as the instant action is not one to recover for a wrongful death.

In the *Harrison* case, the personal representative of the decedent brought the action for the decedent's wrongful death. The trial court admitted, over defendant's objection, the testimony of a physician who treated the deceased during his lifetime, to prove that the injuries received while in a collision caused his death.

The Supreme Court held that that was error, saying:

> "Under the principles announced in the Estate of Flint, 100 Cal. 391, 34 P. 863, the evidence should have been excluded. While the precise question here presented—whether, after the death of the patient, his legal representative may waive the objection which the statute gives, in terms, to the patient alone—was not there directly decided, it was, nevertheless, fully considered and discussed, and the meaning of the statute in that regard very clearly indicated in the following language: 'The question of waiver of the privilege by the personal representative or heir of

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the deceased is a new one in this state, but the statute of New York bearing upon this matter is similar to the provision of our Code of Civil Procedure, and the decisions of the courts of that state furnish us ample light in the form of precedent. The Code of Civil Procedure of New York, section 836, provides that the privilege is present unless "expressly waived by the patient." The California provision contains the words "without the consent of his patient." It will thus be seen that the provisions are in effect the same.

The courts of New York, under this clause of the statute, have uniformly held that the patient alone can waive the privilege and when such patient is dead the matter is forever closed. Westover v. Aetna Life Ins. Co., 99 N. Y. 56, 1 N. E. 104, 52 Am. Rep. 1; Renihan v. Dennin, 103 N. Y. 573, 9 N. E. 320, 57 Am. Rep. 770; Loder v. Whelpley, 111 N. Y. 239, 18 N. E. 874. * * *'

This construction is not unreasonable in view of the peculiar terms of our statute, and is undoubtedly fully supported by the New York authorities referred to in the case just cited; and, since our statute seems to be framed closely after that of New York, the construction given the latter by the courts of that state should have great weight with us in interpreting the meaning of our own."

Subdivision 4 of Section 1881 of the *California Code of Civil Procedure* announces the "policy of the law" and the rule with respect to privileged communications between a physician and his patient as follows:

"There are particular relations in which it is the *policy of the law* to encourage confidence and to preserve it inviolate; therefore, a person cannot be examined as a witness in the following cases:

"(1) * * *

"(2) * * *

"(3) * * *

"(4) A licensed physician or surgeon cannot, without the consent of his patient, *be examined in a civil action,* as to any information acquired in attending the patient, which was necessary to enable him to prescribe or act for the patient; * * *." (Emphasis added.)

In the case of *In re Flint,* 100 Cal. 391, at page 396, the Supreme Court said:

"This provision of law rests upon a sound public policy. Its object and purpose is to enable the patient to make a full statement of his physical infirmities to his physician, with the knowledge that the law recognizes the communications as confidential, and guards against the possibility of his feelings being shocked or his reputation tarnished by their subsequent disclosure. To him, the considerations are even more weighty that the privilege remain inviolate after he has gone to his grave, for his good name is left behind deprived of his protecting care." (Emphasis added.)

In the case of *Kramer v. The Policy Holders Life Insurance Ass'n.,* 5 Cal. App. (2d) 380, the court said in this connection that:

"Our state has proclaimed its attitude in favor of liberal construction. In the case of *McRae v. Erickson,* 1 Cal. App. 326, at pp. 331-332, the court says: 'But to give to the statute this narrow construction would equally exclude from its application many if not most of the answers to questions usually put, and properly and necessarily put, by competent physicians

> to patients in cases of this kind, in order to enable them to act for their patients. This, we think, would be to defeat the obvious purpose of the act, which, it is said, *"is to facilitate and make safe full and confidential disclosure by patient to physician of all facts, circumstances, and symptoms, untrammeled by apprehension of their subsequent and enforced disclosure and publication on the witness stand, to the end that the physician may form a correct opinion, and be enabled safely and efficaciously to treat his patient."* (*Will of Bruendl,* 102 Wis. 47, 78 N. W. 169.) Hence, it is said in the case cited * * *: "The seal placed on the lips of the physician only relates to 'information necessary to enable him to prescribe for such patient as a physician.'" *The tendency of all courts has been and should be toward liberal construction of these words to effectuate the purpose of the statute.'"*

In the case of *Turner v. Redwood Mutual Life Ass'n.,* 13 Cal. App. (2d) 573, 576, the court in this connection, states that:

> "In approaching the question we must bear in mind two well-settled rules of construction in California. (1) *That the provisions of subdivision four of section 1881 of the Code of Civil Procedure should be liberally construed in favor of the patient* (*Kramer v. Policy Holders etc. Assn.,* 5 Cal. App. (2d) 380 (42 Pac. (2d) 665); *McRae v. Erickson,* 1 Cal. App. 326 (82 Pac. 209)), and, (2) *that as the application and insurance policy were both prepared by the insurance carrier, and the provisions here in question are invoked to forfeit the policy, their terms should be strictly construed against it.* (*Witherow v. United American Ins. Co.,* 101 Cal. App. 334 (281 Pac. 668).)" (Emphasis added.)

(d) After the Policy Was Issued, the "Insured's" Waiver of Privilege Was an Integral Part of, and Provision in, the Policy for the Appellee's Benefit; and Its Rights and Powers Thereunder May Not Be Exercised and Enjoyed by it Concurrently With Its Affirmative Repudiation and Prayer for Cancellation and Rescission Thereof.

The "Insured" in the instant case executed a waiver in "Part II," in words and figures as follows:

> "* * * I expressly waive to such extent as may be lawful, on behalf of myself and of any person who shall have or claim any interest in any policy issued hereunder, all provisions of law forbidding any physician or other person who has attended or examined me, or who may hereafter attend or examine me, from disclosing any knowledge or information which he thereby acquired, and I authorize any such disclosure." [II, 406.]

The policy in suit made the application a part of the contract, in words and figures as follows:

> "This policy and the application, a copy of which is attached to and made a part of this policy constitute the entire contract between the parties. All statements made by the insured or in his behalf, in the absence of fraud, shall be deemed representations and not warranties; and no such statements shall be used in defense to a claim unless contained in the application and unless a copy of such application is attached to this policy when issued. * * *" [I, 41.]

Appellant, in "Part I" (the application) the only document signed by him, agreed that:

> "* * * This application, including Part II, a copy of which shall be attached to the policy when issued, shall become a part of every policy issued hereon; * * *" [I, 44.]

Accordingly, therefore, the only valid waiver of privileged communications entitling the Appellee to introduce testimony of the "insured's" attending physician with respect to the "insured's" medical history, health and physical condition, was a part of the policy itself, and an integral part thereof. After the waiver became merged into the contract, the insurer's subsequent exercise of its power to elicit information from the insured's attending physicians with respect to privileged matter was an exercise of a right accruing to Appellee under the contract. It is a well recognized rule that

> "The insurer may not repudiate the policy, deny all liability, and at the same time be permitted to stand on a provision inserted in the policy for its benefit."
>
> *Grant v. Sun Indemnity Co.* (1938), 11 Cal. (2d) 438, 440.

and cases there cited.

> *Austin v. Hallmark Oil Co.* (1943), 21 Cal. (2d) 718, 727 (5);
>
> 10 *Cal. Jur.,* Sec. 25, p. 645.

(e) The Trial Court Erred in Admitting the Testimony of the Deceased Insured's Attending Physicians Over Appellant's Objections. In the Absence of Such Testimony, There Is No Evidence in Support of the Judgment.

The testimony of the insured's attending physicians, Dr. Rosenfeld and Dr. Seech, admitted over Appellant's objections, was also error because such evidence was hearsay insofar, at least, as the statements of the "insured" to the doctors were concerned.

Yore v. Booth, 110 Cal. 238.

The propriety of the application of the rule of law stated in *Yore v. Booth, supra,* is emphasized in the case at bar for the reason that in the *Booth* case, the *third party beneficiary* was the plaintiff suing, and she was merely the object of the insured's bounty under a contract of insurance which the insured made with the insurance company, while in the case at bar, the Appellant, in his own behalf and for his own benefit, rather than the insured, entered into the insurance contract with the Appellee insurer.

In the *Booth* case the court said, at pages 240, 241:

> "* * * A person who procures a policy upon his own life, payable to a designated beneficiary, although he pays the premiums himself, and keeps the policy in his exclusive possession, has no power to change the beneficiary, unless the policy itself, or the charter of the insurance company, so provides. In other words, it is held that the beneficiary named in the policy, although he has parted with nothing, and is simply the object of another's bounty, has acquired a vested and irrevocable interest in the policy, which

> he may keep alive for his own benefit by paying the premiums or assessments if the person who effected the insurance fails or refuses to do so."

In the *Booth* case, the defendant, to avoid liability, urged that the insured falsely answered questions in the application with respect to his age, and offered evidence of the insured's *prior* statements inconsistent with the answers in the insured's application. This evidence was rejected on the ground that it was hearsay and the Supreme Court affirmed the judgment of the trial court on that ground, saying at pages 241, 242:

> "* * * Any declarations of the deceased, not made at the time of procuring the policy, or as part of the *res gestae,* were *hearsay* and incompetent. * * *" (Emphasis added.)

(f) All Answers to the Printed Questions in Part II of the Application Are Written by and in the Longhand of the Medical Examiner and Represent His Interpretation of That Which He Considered the Material Portion of the Insured's Answers to the Medical Examiner's Interpretation, and in One Instance Admittedly Erroneous Interpretation, of the Printed Questions.

The insured was Yiddish, was Jewish, read Hebrew but didn't read English well. The evidence showed, the court said, that he didn't read documents but he understood them when they were read to him, and he always had important documents read to him. Lawyers by whom he had been advised testified that, when they did anything for him, they read the documents to him or that someone came in and read them to him and then he exercised his judgment predicated upon what he heard [I, 359-360].

In propounding his interpretation of the printed questions in Part II to the "insured," the medical examiner sat across the desk from the "insured" facing him [I, 202]. All answers written in Part II were written in longhand by the medical examiner [I, 201]. The insured wrote nothing on Part II other than his own signature [I, 201]. After the medical examiner completed all the questions he turned the document around and asked the "insured" to sign it [I, 222].

The medical examiner did not record all of the insured's answers or such of the insured's answers as the medical examiner thought were "immaterial" [I. 215]. Some of insured's answers omitted in "Part II" were included in the medical examiner's confidential report [I, 214-15, 222]. The medical examiner did not ask all of the printed questions in "Part II" correctly, *e. g.,* subdivision "B" of question 35 indicates that the insured answered that he had *never* suffered from "insomnia." The question as printed is: "Have you ever suffered from: Insomnia?" The answer written by the medical examiner is: "No." *The "insured" made no such reply* to the question as printed. Actually, the "insured's" reply was: "yes" to the medical examiner's erroneous interpretation of the question, viz.: in interpreting that printed question and propounding it to the "insured," the medical examiner asked the "insured," and here we quote the record testimony of the medical examiner:

> "I asked him (meaning the insured) if he slept well. He (meaning the insured) said 'yes.' That answer would be 'No' for insomnia" [I, 213].

The medical examiner's mistake in this respect is very natural and in no sense surprising in retrospect when consideration is given to the *form* of the printed question which appears as Number 35 in "Part II" to wit:

Have you ever suffered from: 35 (Give details under 44)		A. Indigestion?	No.	B. Insomnia?	No
C. Nervous strain or depression?	No.	D. Overwork?	No.	E. Dizziness or fainting spells?	No
F. Palpitation of heart?	No.	G. Shortness of breath?	No.	H. Pain or pressure in the chest?	No

It is obviously easy to *not read*: "Have you *ever* suffered from:" (emphasis added) before each of the eight (8) subdivisions of the above reproduction of number 35 of "Part II". However, that is precisely the admission of that which the medical examiner did with respect to subdivision "B" thereof [I, 213]. Perhaps the medical examiner's admission in this regard was an inadvertence while on the witness stand. If it was merely an inadvertence, it demonstrates how easily it can be and probably was slipped into with respect to the other seven subdivisions. If it can be so easily slipped into in open court when the witness's attention to the matter is concentrated and he is on the alert, it is obvious that the same inadvertence is more probable in the press of routine office procedure and expedition.

In further corroboration of the probability that the medical examiner failed to read "Have you ever suffered from:" before all of the 8 subdivisions of "35," is the striking coincidence that all the answers are "No," which is comprehensible if the medical examiner asked "*Do* you suffer from": or "do you *now* suffer from:" before each of the 8 subdivisions. On the other hand, it is *incredible*

that a man 64 years of age would say, or believe it credible to say, or that Appellee or its medical examiner or its medical director would believe that during all of his life of 64 years the insured had *never* suffered from "indigestion," "insomnia," "nervous strain or depression," "overwork," "dizziness or fainting spells," "palpitation of heart," "shortness of breath" or "pain or pressure in the chest." It is preposterous that Appellee should have believed or relied upon a statement that any person 64 years old, who had a history of diabetes, sugar or albumen in his blood and previously rejected for insurance, *never* in 64 years had suffered from *any* of the maladies named.

Some parts of the answers in "Part II" are not even interpretations of answers of the "insured," and on the contrary represent answers furnished by the medical examiner himself. This is demonstrated in several instances, *e. g.,* 36B of "Part II" requests the "insured" to "give reasons, name of practitioner and details under 44" if the "insured" had consulted or been examined by a physician or other practitioner within 5 years. Pursuant thereto, the medical examiner wrote under "Special Information" at 44 in his own longhand:

> "Dr. Maurice H. Rosenfeld, 1908 August 1942 Physical examination and blood sugar determination report was normal."

In explanation of the source of his information concerning and the meaning of "1908" in the last quotation above, the medical examiner explained as follows on his direct examination:

> "Q. His (Dr. Maurice H. Rosenfeld) address, 1908 Wilshire Blvd? A. Yes.
>
> Q. Did you just fail to put in 'Wilshire Boulevard'? A. That's right. [I, 216.]

Q. You did not make an error; you just failed to put in 'Wilshire Boulevard'? A. I omitted it, yes.

* * * * * * * *

Q. The court has suggested that the full address of the doctor was not listed on your item 44. Does that refresh your memory as to whether or not Mr. Lutz (the insured) said he had consulted Dr. Maurice H. Rosenfeld at 1908 Wilshire Boulevard? A. No, that's the office address of the doctor he consulted.

Q. From whom did you get the office address of Dr. Maurice H. Rosenfeld? A. I knew it. That's where his office was." [I, 217.]

(g) The Appellee Had Placed at Its Disposal the "Exact Source" of Information From Which It Could Have Obtained Full and Complete Information on Everything It Now Claims Was Withheld From, and Misrepresented to, It.

The "insured" gave Appellee the name of his attending physician, Dr. Maurice H. Rosenfeld, whose testimony, introduced over Appellant's objection in the trial of this case, demonstrated that he was thoroughly conversant with and readily disclosed every item of fact with respect to every item of alleged fraud, concealment and misrepresentation upon which Appellee relies and the judgment is premised.

The insured's concurrent waiver of privilege and express authorization for the revelation to Appellee of all privileged communications by "any physician or other person who has attended or examined me," obviously included Dr. Rosenfeld and placed at Appellee's disposal the "exact source" of information from which it could have obtained,

and after the "insured's" death it did obtain, full and complete information on everything Appellee now claims was withheld from it.

The testimony, admitted over Appellant's objection, of Dr. Maurice H. Rosenfeld, the "insured's" attending physician, showed that *if Appellee had inquired of Dr. Rosenfeld,* under the "insured's" waiver of privilege in "Part II," *it would have received and elicited from him* prior to the issuance of the policy in suit, *the following information,* to wit (in the order of the "insured's" consultations with the doctor):

> 1. First consulted by insured on January 16, 1937 [I, 101] who complained of dizziness, vertigo and inability to get out of bed [I, 102]. While the doctor diagnosed the condition as "probable slight" stroke which he "suspected as being very mild" and found some hardening of the arteries or arteriosclerosis and advised rest [I, 103], he did not tell the insured that he had suffered or sustained a stroke; the insured was told "that his general condition was satisfactory" but that the "question of a possible stroke had to be considered in view of the symptoms and the eye ground findings" [I, 134] made by an eye specialist, Dr. Stephen Seech, with whom Dr. Rosenfeld communicated directly [I, 124-125]. The insured had no pains [I, 142].
>
> (Over Appellant's objection [I, 156], Stephen G. Seech, M. D., specializing in ophthalmology [I, 155] with whom Dr. Rosenfeld communicated directly [I, 124-125], testified that he was consulted by the "insured": on January 15, 1937 [I, 155], complaining that two days earlier he awakened with a dizzy head and was nauseated [I, 156].)

2. On January 19, 1937, Dr. Rosenfeld saw the "insured" again and the treatment was discussed. That was the last time Dr. Rosenfeld saw the insured for a number of years [I, 135].

3. On June 1, 1942, over 5 years after the last previous consultation, Dr. Rosenfeld next saw [I, 135] and examined [I, 105] the "insured" at which time he gave the "insured" a complete physical examination, made an electrocardiographic study and further study of the "insured's" blood, blood sugar, blood count and urinalysis. The doctor found the "insured" had an elevated abnormal blood sugar; blood pressure slightly elevated; a mild coronary ischemia [I, 105] which "is transitory" [I, 106] while the "probable" narrowing of the coronary arteries is chronic and "probably" progressive. The diagnosis was "probably" angina pectoris "probably" due to the coronary artery narrowing. The "insured" was advised to curtail activities, reduce weight by diet, "to improve this potential diabetic condition" and was given nitroglycerine, (sometimes prescribed for high blood pressure) [I, 135], for relief of pain [I, 106 & 137], which the "insured" for the first time complained of getting around his heart [I, 142] and which the "insured" thought were "gas" pains [I, 136]. The doctor's "suspicions" were that the "insured" had "mild" angina pectoris. The symptoms "were very mild" [I, 136]. The diagnosis of angina pectoris was "suspected" [I, 107], but it was Dr. Rosenfeld's policy, when he found a condition involving a suspicion of heart infirmity, not to make any statements which would make the patient unduly apprehensive [I, 119, 135]. The "insured" was also told about his "potential diabetic condition" [I, 107].

4. On June 3, 1942, Dr. Rosenfeld advised the "insured" that there was some abnormality in the cardio-

gram, not seen in the previous studies, which indicated that the pains of which the insured complained were due to his heart and "suggested" angina pectoris [I, 111]. In his testimony Dr. Rosenfeld said he found excessive sugar in the insured's blood on "one" occasion which he identified as this occasion, *i. e.*, June 3, 1942, [I, 145] although he previously testified he found on June 1, 1942, that the insured had an elevated abnormal blood sugar [I, 105].

5. On June 5, 1942, the "insured" had no complaints [I, 107]. The doctor made no examinations [I, 137].

6. On June 12, 1942, the "insured" said he had been feeling better than he had on the previous visits. He did not complain of pain, pressure in the chest or dizziness [I, 137].

7. On July 6, 1942, the "insured" stated he was feeling very much better; he said he was much improved [I, 138] and had no complaints [I, 115]. While the doctor "suspected the possibility of an acute coronary occlusion" and continued to believe that the "insured" had arteriosclerosis and angina pectoris [I, 116], nevertheless, he did not tell the "insured" what his diagnosis and conclusions were [I, 117]. The doctor testified that said diagnosis and conclusions were "just for my own information and a follow up for further diagnostic evidence" [I, 117]. The electrocardiograms taken on this date showed definite improvement and the doctor so advised the "insured" and recommended a "little vacation" [I, 139].

8. On August 7, 1942, the "insured" had no complaints and no pains [I, 140]. The doctor made a blood sugar test, found it to be normal, and so advised the "insured" [I, 140]. The examina-

tion and discussion that day "was primarily referable to the patient's diabetic problem" and the doctor told the "insured" "that his blood sugar was essentially normal" [I, 118]. Having in mind the "insured's" age, 64, it was the doctor's opinion that the "insured" was in a good state of health "except for the pains and slight electrocardiograph changes" [I, 140].

9. On August 11, 1942, the last time the doctor saw the insured before November 16, 1942, when the latter signed the application [I, 144], the "insured" had no complaints; he was re-examined and another electrocardiogram was taken. The doctor advised that although his suspicion was the same, nevertheless "there was no increase in impairment noticed" [I, 118]. The overall picture was that the "insured" was improving; he was better. From June 5, 1942, to August 11, 1942, he had improved [I, 141]. His blood pressure [I, 144] and blood sugar were normal [I, 145]. He was recovered from the pain [I, 150]. The appearance of the "insured" was that of a normal appearing man in every way [I, 144].

On April 7, 1944, or 19 months later, Dr. Rosenfeld in his office next [I, 143], and for the last time, saw the "insured" before his fatal illness [I, 144]. Dr. Rosenfeld did not see [I, 143] nor prescribe any medicine for [I, 144] the "insured" from August 11, 1942 to April 7, 1944 [I, 143-144].

Dr. Rosenfeld further testified that the insured died of "an accute attack of coronary thrombosis" [I, 119], which probably occurred several hours before his death [I, 143], but was sent to the hospital for an acute duodenal ulcer, *i. e.,* ulcer of the stomach [I, 120]. In all of the doctor's examinations, there were no symptoms which could be as-

cribed to coronary thrombosis [I, 144]. Normal, healthy appearing people suffer from fatal attacks of coronary thrombosis without any previous symptoms and Dr. Rosenfeld could not determine in August, 1942, from any examination that he could or did make as a heart specialist, whether or not the insured had coronary thrombosis [I, 143].

It is possible for a person to have mild angina pectoris and thereafter effect a complete recovery. Many times a person will have all the symptoms of mild angina and, over a period of time and treatment, can completely recover [I, 149].

While, over Appellant's objection [I, 122-123], Dr. Rosenfeld stated that it was his "belief" that the "insured" had arteriosclerosis and angina pectoris during the 39 day period between Nov. 1, 1942 and Dec. 9, 1942 [I, 122-123], nevertheless, he did not see the "insured" or prescribe any medicine for him during the over 19-months period between August 11, 1942 to April 7, 1944 [I, 143-144] and this evidence of Dr. Rosenfeld with reference to said 39 day period should have been, and the trial court thought that it was, excluded as is demonstrated in the court's opinion where Judge Jenney, speaking of the evidence elicited from Dr. Rosenfeld, said:

> "The testimony limits the information obtained by Dr. Rosenfeld from the deceased to that period of time prior to November 16, 1942" [I, 355].

Dr. Rosenfeld testified that during the months of November and December, 1942, and Jannary, 1943, his office address was 1908 Wilshire Boulevard; telephone number was EXposition 1369; his bookkeeper's name was Miss Byington [I, 146] and that during that period he did not

[I, 148] receive any letters or communications from Appellee, New England Mutual Life Insurance Company of Boston, a corporation, with reference to the health, condition or treatment of the "insured" [I, 147-148] but that shortly after the "insured's" death, *i. e.,* subsequent to May 28, 1944, Dr. Rosenfeld received a form from Appellee to fill out [I, 148].

Dr. Rosenfeld thought he was in his own office [I, 151] when he filled out the certificate of death [Ex. C] which certified that the insured's cause of death was "acute coronary thrombosis" of only one day's duration; "angina pectoris" of a duration of "1 yr +" and duodenal ulcer of a duration of "2 Mo. +" [II, 420].

The "insured's" complaint of "gas" pains had nothing to do with "indigestion". There is no evidence in the record that the "insured" suffered from "indigestion". Dr. Rosenfeld explained (emphasis added) that when a "gas" pain "occurs on effort or on emotion, it becomes obvious that *the stomach is not the thing at fault,* but the heart. However, most patients who complain of pain or a peculiar sensation that is hard for them to describe, and they usually say it is gas pains primarily because of belching, and they say, 'I feel badly.' *This is a very common fallacy* and the differential point is that gas pains usually are associated in close relation to the intake of food, while the gas pain as caused by heart disease is related to emotion and strain" [I, 126].

While the "insured" complained of pain on June 1, 1942 [I, 142], which Dr. Rosenfeld said was due to the

heart [I, 107] and not the stomach [I, 126], which the "insured" considered a "gas" pain [I, 136], nevertheless the fact remains that the "insured" never had any condition which was diagnosed as "indigestion" or "palpitation of the heart.' Unless pain in the "heart" is synonomous with pain in the "chest," the "insured" never had any pain in the chest and certainly he had no condition diagnosed as pain *or pressure* in the "chest."

The appellee was in possession of facts which put it on notice and inquiry and which, if pursued, would have given it actual knowledge and full and complete information concerning everything it now claims was withheld from and misrepresented to it. Its failure to make such inquiry, when it could have conveniently done so, constitutes notice of that which the inquiry would have disclosed, and this constitutes a waiver of all right to complain that such information was withheld from or misrepresented to it.

An insurance company may be charged with knowledge of facts which it ought to have known.

Columbian Nat. Life Ins. Co. v. Rodgers, 116 F. (2d) 705, citing

Supreme Lodge K. P. v. Kalinski, 163 U. S. 289, 41 L. Ed. 163.

In the *Columbian National Life Insurance Co.* case, *supra,* the beneficiary brought the action on a $10,000 policy issued by the defendant insurance company on Feb. 5, 1935, where the insured died less than 6 months later, on August 4, 1935. The defendant insurer claimed that

the insured made false and fraudulent representations in his application in response to questions as to whether he had ever been declined insurance. The evidence showed:

1. The insured had previously applied to and was declined insurance by John Hancock Mutual Life Ins. Co.;
2. After the John Hancock Co. declined the issuance of a policy, information that it had the insured's application, and some other company has created a record against him, was given to members of the Medical Information Bureau ("MIB") without stating whether John Hancock Co. had issued or declined to issue a policy;
3. The above MIB information was in defendant's possession and before its proper agents when it issued the policy after previously having notified its agent that its delay on the application was because it was investigating Applicant's previous insurance record.
4. There was no evidence as to the investigation the defendant made but it was established that defendant made no investigation of John Hancock Co. which latter company imparted no information to the defendant prior to the latter's issuance of the policy in suit.

The court held that the defendant was put upon inquiry by information before it when it issued the policy and was estopped to assert that it was without knowledge concerning the facts involved in the previous unsuccessful application to obtain insurance.

Keeping in mind the fact that in the instant case the contract was between the Appellee insurer and the *assured* Appellant, and not with the latter's father, the so-

called "insured," the following sections of the Insurance Code demonstrate the impropriety of permitting the insurer to complain of the third party's (the "insured's") alleged concealment or misrepresentation:

PRESUMED KNOWLEDGE.

"Each party to a contract of insurance is bound to know:

(a) All the general causes which are open to his inquiry equally with that of the other, and which may affect either the political or material perils contemplated.

(b) All the general usages of trade."

335 *California Insurance Code.*

WAIVER OF RIGHT TO INFORMATION.

"The right to information of material facts may be waived * * * by neglect to make inquiries as to such facts, where they are distinctly implied in other facts of which information is communicated."

336 *California Insurance Code.*

MATTERS NOT REQUIRED TO BE DISCLOSED EXCEPT UPON INQUIRY.

"Neither party to a contract of insurance is bound to communicate information of the matters following, except in answer to the inquiries of the other:

1. Those which the other knows.
2. Those which, in the exercise of ordinary care, the other ought to know, and of which the party has no reason to suppose him ignorant.
3. Those of which the other waives communication.
4. * * *
5. * * *

333 *California Insurance Code.*

Paraphrasing the above Insurance Code sections:

The Appellee insurer is bound *to know* the matters which "are open to" Appellee's "inquiry equally with that of the" Appellant. (335 Insurance Code.)

Appellee's right to information of material facts were waived by its neglect to make inquiries with respect thereto until after the loss occurred where such facts were distinctly implied in other facts communicated to Appellee with reference to diabetes, previous application for insurance rejected, consultation with heart specialist whose name was given together with express waiver of privilege and authorization for full disclosure (336 Insurance Code).

Appellant, *even if he were* conversant therewith, is under no duty to communicate information to Appellee with respect to matters which Appellee, in the exercise of ordinary care, ought to know, in the absence of Appellee's direct inquiry *of Appellant* with respect thereto (333 Insurance Code).

Required Disclosures.

> "Each party to a contract of insurance shall communicate to the other, in good faith, all facts *within his knowledge* which are or which he believes to be material to the contract and as to which he makes no warranty, *and which the other has not the means of ascertaining.*" (Emphasis added.)
>
> 332 *California Insurance Code.*

Paraphrasing the above quoted Section 332, Appellant was under a duty to communicate to Appellee all facts *within Appellants knowledge* which Appellee did not have "the means of ascertaining." Clearly, the Appellee had

"the means of ascertaining" from Dr. Rosenfeld all of the facts and information which it now claims was misrepresented to or withheld from it, and *there is no allegation or finding that such information was within Appellant's knowledge.*

In the *Columbian National Life Insurance Co.* case, the beneficiary was suing on a contract between the insurer and the "insured" and as to which the plaintiff was only a third party beneficiary. In the case at bar, Appellant is suing on his own contract.

The case of *Turner v. Redwood Mutual Life Ass'n,* 13 Cal. App. (2d) 573 (hearing denied June 26, 1936), approved the doctrine of waiver and estoppel applicable in the case at bar. The insurance company in the *Turner* case, in the language of the decision (p. 575):

> "* * * sought to relieve defendant from liability under its policy because of *alleged fraud* on the part of the *insured* in making *untrue answers* in her *application* for the policy and in an application for its reinstatement made July 10, 1934. Defendant *asserts* that Mrs. Turner had suffered from *twenty-three ailments during the period between October 18, 1925, three years prior to the date of the application,* and the date of her death, and that these were *concealed* from defendant constituting *fraud* on her part voiding the insurance. It sought to support this defense by the *evidence* of the *physicians* who had *attended Mrs. Turner.* The trial court excluded the evidence of these witnesses under the provisions of subdivision four of Section 1881 of the Code of Civil Procedure. Defendant maintains that the provisions of this section were waived by Mrs. Turner by the quoted paragraph in her application

for insurance and that the testimony of the physicians who had treated her was therefore admissible." (Emphasis added.)

On page 578 of the *Turner* case, the court said:

> *"She gave the names of her attending physicians and defendant could have ascertained the exact nature of her illness and treatment had it sought that information before it issued its policy.* There is nothing to show that the operation was not a complete success and that she had not 'fully recovered' from that illness as stated in the application." (Emphasis added.)

There, as here, the information which the insurance company claimed was withheld from it could have been obtained from the doctors whose names were listed on the application. In holding that the insurance company had waived any misstatement in the application and was estopped from asserting the purported fraud, the court said on page 578:

> *"Defendant had placed at its disposal the exact source from which it could obtain the information which it now maintains was withheld from it. It did not choose to make any inquiry but issued its policy with extreme promptness, to say the least, and accepted deceased's money for six years, during all of which time defendant led her to believe she had a valid and enforceable policy of insurance on her life. Under such circumstances defendant should not be permitted to come into court after death had sealed the insured's lips and prevented her from explaining, if she could, why she did not mention an operation in 1926, when she did mention an illness and treatment by physicians which, we conclude from the evidence and proffer of proof occurred at the same time as the operation.* The illness and some treatment, though

> not the correct organ involved, were disclosed, and only the fact of an operation to effect a cure was withheld. *As defendant made no investigation when it should and could have, and as it issued its policy of insurance, accepted Mrs. Turner's money for six years and lulled her into the secure belief that she had a valid policy of life insurance, it must be held that it waived the misstatement in the application and is now estopped from asserting the purported fraud.*" (Emphasis added.)

In *Columbian Nat'l Life Ins. Co. v. Rodgers,* 116 F. (2d) 705, 707, the court said in this connection:

> "An insurance company may be charged with knowledge of facts which it ought to have known. See, Supreme Lodge K. P. v. Kalinski, 163 U. S. 289, 16 S. Ct. 1047, 41 L. Ed. 163. Knowledge which is sufficient to lead a prudent person to inquire about the matter, when it could have been ascertained conveniently, constitutes notice of whatever the inquiry would have disclosed."

(h) There Was No Fraud or Concealment.

Appellee claims, and the trial court, by finding XI, found [I, 52-53], that the insured concealed from it information to the effect that

> Within 5 years the insured on numerous occasions other than in August, 1942, had consulted and been examined by physicians, had electrocardiograms taken, medicine prescribed to relieve heart pains, received treatment for and been told by his physician that he had angina pectoris and should curtail his activities,

by the insured's response, in the medical examiner's longhand under item 44, to the direction in item 36 B to "give

reasons, name of practitioner and details under 44" if the "insured" had consulted or been examined by a physician or other practitioner *within 5 years* [I, 44], to wit:

> "Dr. Maurice H. Rosenfeld 1908 August 1942 physical examination and blood sugar determination report was normal." [II, 406; I, 44.]

This criticism is wholly unwarranted, and there is no support in law or fact for such a finding for the reason that question 36A (answer in quotation), viz:

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36 A Have you consulted or been examined by, a physician or other practitioner within 5 years? "Yes"

B If so, give reasons, name of practitioner and details under 44

---

and particularly subdivision "B" thereof by a proper interpretation, and we don't know how the medical examiner read or interpreted it to the insured, does *not* request:

(1) That the insured state all reasons which may have prompted *all* consultations or examinations by *all* physicians or other practitioners over the whole 5 year period; or

(2) That the insured specify how many times in the then last 5 years he had consulted or been examined by a physician or other practitioner; or

(3) That the insured specify all or any diagnoses made and all or any treatments received over the whole 5 year period or any part thereof; or

(4) That the insured specify whether electrocardiograms were taken or how many were taken over the 5 year period; or

(5) That the insured name *all* physicians and other practitioners whom he consulted or by whom he was examined; or

(6) That the insured explain *all* or any prognoses made, recommendations offered, prescriptions written or medicines prescribed; or

(7) That the insured elaborate all or any symptoms, pains, or anxieties that had prompted each or every consultation with or examination by each or every physician or practitioner whom he had consulted or been examined by during the entire 5 year period.

It is Appellant's position that question 36, as properly interpreted, was correctly answered without concealment either in fact or legal contemplation when the medical examiner in his own longhand wrote:

(1) The word "yes" in response to subdivision question "A" thereof, to wit: "Have you consulted or been examined by a physician or other practitioner within 5 years?"; and

(2) In response to the subdivision "B" direction therein ("If so, give reasons, name of practitioner and details under 44"), the following:

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44 Special Information:

"36. Dr. Maurice H. Rosenfeld—1908—August—1942—Physical Examination & blood sugar Determination—report was normal"

The space provided in 44 for explanation or "Special Information" is so small [I. 44] as to indicate that no complete 5 year medical and diagnostic history is contemplated. Furthermore, the above quoted "Special Information" at 44, as written by the medical examiner, bears the interpre-

tation (by reason of the unintelligibility, uncertainty and ambiguity of the phrase "1908 August 1942"): that the "insured" had consulted and been examined by Dr. Rosenfeld over the period of from 1908 to August 1942, and not merely on one occasion in August, 1942, as it is construed in finding XI [I, 52-53].

The Appellee was well aware of the fact that its "Part II" and particularly question 36 "B" therein, did *not* request the "insured" to furnish, and that he had not furnished, as "Special Information" under 44, *all* "reasons" for, or *all* "details" of, the insured's consultation with or examination by Dr. Rosenfeld. This is demonstrated by Appellee's letter [II, 432] in explanation of telegram [II, 427] dated Dec. 1, 1942, advising that the issuance of the policy in suit was approved but that Appellee was unable to consider two additional policies requested aggregating an *additional* $13,000 on the life of the "insured" "without a complete detailed statement from Dr. Rosenfeld *and Dr. Lisner*" (emphasis added), and that Appellee would like, to further quote Appellee's said letter, "*full* details" (emphasis added) as to:

(a) "Why were the doctors consulted?"
(b) "What were the symptoms?"
(c) "What were the findings?"
(d) "What treatment or advice was given?"
(e) "What were the results?" [II, 432.]

Obviously Appellee was not only "on notice" but also "on inquiry". Nevertheless, Appellee claims that it was misled by, and there was fraud in, the "insured's" "No" answer to 4 interrogatories in 35, relative to:

"A Indigestion?"
"E Dizziness or fainting spells?"
"F Palpitation of heart?"
"H Pain or pressure in the chest?"

Appellee was not misled by any of the "No" answers to any of the above mentioned 4 interrogatories in 35. The only one of those "No" answers which could possibly be considered incorrect is the one in response to subdivision "E" with reference to

"Dizziness or fainting spells?"

This question in "Part II" appears immediately below the inquiry with reference to "Insomnia?" [II, 406] which the medical examiner clearly misinterpreted and erroneously propounded to the "insured" by *failing to ask* the "insured" if he had "ever" suffered from insomnia, as the printed question technically appears, and actually the medical examiner asked the "insured":

"Do you sleep well?" [I, 213].

The "insured" answered "yes" [I, 213] and the medical examiner, on the witness stand in open court still obtuse to the significance of the printed question, interpreted the answer of the "insured" as follows:

"That answer would be 'No' for insomnia" [I, 213].

While the medical examiner claims to have asked the "insured" whether he ever suffered from dizziness or fainting spells, it is obvious from the medical examiner's treatment of the inquiry with reference to insomnia (which in 35 of Part II appears immediately before and above), that the question probably and undoubtedly propounded to the "insured" in this connection was:

"Do you suffer from dizziness or fainting spells?"

meaning do you *now* or *currently* suffer from dizziness or fainting spells?

While it is true that on January 15, 1937 [I, 155], *over* 5 years prior to (November 16, 1942) the date on which

said "Part II" was signed by the "insured", he did complain of dizziness to the eye specialist, Dr. Seech [I, 156], and the next day with respect to the same complaint consulted Dr. Rosenfeld [I, 102], on May 21, 1938, the findings of Dr. Seech with respect to the same complaint were negative [I, 162]. That is all the evidence with respect to dizziness except that there is no evidence that the "insured" ever complained of dizziness again and there is substantial affirmative evidence that he *never again so complained* [I, 118, 137, 140].

"A. Indigestion?"

There is not any evidence in the record that the "insured" *ever* suffered from "indigestion". Dr. Rosenfeld explained [I, 126] that the so called "gas" pains with which the insured suffered were due to the heart; "the stomach is not the thing at fault".

"F. Palpitation of the heart?"

While the "insured" complained of heart pains, he *never* complained of "palpitation of the heart" and Dr. Rosenfeld's only diagnosis in this connection was "probably" angina pectoris "probably" due to the coronary artery narrowing [I, 106]. There is no evidence that the "insured" *ever* suffered from palpitation of the heart. Finding IX [I, 52] is ambiguous as to this.

"H. Pain or pressure in the chest?"

The "heart" is to be distinguished from the "chest". The "insured" did complain of pain in the region of his heart which on June 1, 1942, he thought were "gas" pains [I, 136] until Dr. Rosenfeld on that day explained that the pains were in, and due to, the heart itself rather than "gas" and that a diagnosis of angina pectoris was "sus-

pected" [I, 107]. Thereafter the pains disappeared [I, 107, 118, 137, 115, 140] which the doctor attributed to the "insured's" restriction of activity rather than to the nitroglycerine [I, 137] which is also prescribed for high blood pressure [I, 135].

Unless the terms "heart" and "chest" are synonymous and interchangeable, the "insured" *never* had any pain in the chest and certainly he had no condition diagnosed as "pressure" in the chest.

In *Lyon v. United Moderns,* 148 Cal. 470, the Supreme Court said in this connection:

> "It must be recognized that the rule applicable in the construction of insurance contracts of construing the contract in favor of the assured and against the insurer, where it is reasonably susceptible of such construction, is applicable in such cases, *'where an insurance company or association seeks to avoid a policy or certificate of membership on the ground of falsity in an answer to a question which is by the terms of the contract made material, the court will construe the question and answer strictly as against the company, and liberally with reference to the insured,'* and, *'if any construction can reasonably be put on the question and the answer such as will avoid a forfeiture of the policy on the ground of falsity of the answer, that construction will be given, and the policy will be sustained.'* (Newton v. Southwestern Mut. Life Assn., 116 Iowa, 311, (90 N. W. 73)." (Italics supplied.)

Furthermore, if the medical examiner asked the "insured": *"Do you have",* rather than "Have you ever suffered from", pain or pressure in the chest, as the medical examiner undeniably and erroneously did with respect to the inquiry regarding "insomnia", it is obvious that the answer of the "insured" was correct. Cooley's Briefs on

the Law of Insurance (Vol. 3, p. 2594) is quoted with approval in *Lyon v. United Moderns, supra,* as follows:

> "From an examination of the cases the following propositions may be regarded as established by the weight of authority: Where the insured, in good faith, makes truthful answers to the questions contained in the application, but his answers, owing to the fraud, mistake, or negligence of the agent filling out the application, are incorrectly transcribed, the company is estopped to assert their falsity as a defense to the policy. The acts of the agent, whether he is a general agent with power to issue policies, a soliciting agent, *or merely the medical examiner for the company,* are in this respect the acts of the company, and he cannot be regarded as the agent of the insured, though it is so stipulated in the application or policy." (Emphasis added.)

While the pharmacist, H. C. Ludden, on March 23, 1945 [I, 79], testified, over Appellant's objection [I, 84], that the "insured" on June 1, 1942 [I, 84] "remarked that he did have a pain in his chest" [I, 88], nevertheless, the witness corroborated Dr. Rosenfeld's testimony that the pain was in the *heart,* rather than in the chest, of which fact the "insured" was again so advised and admonished by the directions which the witness Ludden said he placed on the bottle [I, 94, 95], to wit:

> "Dissolve one tablet under tongue for *heart* pain." (Emphasis added.)

As stated in the case of *Turner v. Redwood Mutual Life Ass'n,* 13 Cal. App. (2d) 575, at 578:

> "* * * *Under such circumstances defendant should not be permitted to come into court after death had sealed the insured's lips and prevented her from explaining, if she could, why she did not mention an*

operation in 1926, when she did mention an illness and treatment by physicians which, we conclude from the evidence and proffer of proof, occurred at the same time as the operation. The illness and some treatment, though not the correct organ involved, were disclosed, and only the fact of an operation to effect a cure was withheld. As defendant made no investigation when it should and could have, and as it issued its policy of insurance, accepted Mrs. Turner's money for six years and lulled her into the secure belief that she had a valid policy of life insurance, it must be held that it waived the misstatement in the application and is now estopped from asserting the purported fraud." (Emphasis added.)

(i) Appellee Has Not Sustained the Burden of Proof, and There Is No Competent Evidence, With Respect to Any Unfavorable State of the Insured's Health When the Application Was Approved or When the First Premium Was Paid or When the Policy Was Delivered.

The application was approved November 27, 1942 [I, 255]. The policy was delivered and the first premium was paid on or about some date between December 7th and 9th, 1942 [I, 384].

Between August 11, 1942 and April 7, 1944, Dr. Rosenfeld did not see or prescribe any medicine for the insured [I, 143-144]. The trial court limited Dr. Rosenfeld's testimony to the information obtained by him *prior* to November 16, 1942 [I, 355].

The Appellee's medical examiner has been a practicing physician since 1910 [I, 199], has practiced or been admitted to practice in California since 1917 [I, 199] and has specialized in physical examinations of persons who apply for insurance since 1927 [I, 199].

On November 16, 1942 [I, 201], after giving the "insured" a physical examination [I, 207, 221] and having in mind the fact that the insured was 64 years of age [I, 212], it was the opinion of the medical examiner that the insured was in *good health* [I, 212], a *normal state of health* [I, 211], and an *insurable risk* [I, 219].

The insured died of an acute attack of coronary thrombosis [I, 119]. He was sent to the hospital for an acute ulcer of the stomach [I, 120]. It is possible for a person to have mild angina pectoris and thereafter effect a complete recovery and many times a person will have all the symptoms of mild angina and over a period of time and treatment can completely recover [I, 149]. Normal healthy appearing people suffer from fatal attacks of coronary thrombosis without any previous symptoms [I, 143]. On August 11, 1942 [I, 144], when Dr. Rosenfeld last saw the insured before the latter signed "Part II" on November 16, 1942 [II, 406], the insured had no complaints [I, 118] and although the doctor testified his "suspicion" was the same [I, 118], nevertheless, the insured was improving and was better [I, 141]. His blood pressure [I, 144] and blood sugar were normal [I, 145]. He was recovered from the pain [I, 150]. The appearance of the insured was that of a normal appearing man in every way [I, 144].

There is no competent evidence that the insured was not in good health at all times between November 16, 1942 when "Part II" was signed to and including December 9, 1942, when the policy was delivered and the premium was paid [II, 384].

Summary.

The Appellant was guilty of no fraud, misrepresentation or concealment, and the "insured" was innocent thereof. Question 36 A in "Part II" asked whether the "insured" had consulted or been examined by "a physician" within 5 years; not how many, as Appellee claims and is implied in the trial court's Finding XI.

Appellee's medical director [I, 247], Harold M. Frost, M. D. [I, 246], who approved [I, 255] the application, testified that he knew that the insured had consulted a doctor other than the one mentioned by the "insured" in "Part II" [I, 295]. This knowledge, and information that the "insured" had been previously rejected for insurance on account of sugar in his urine [I, 216], had a history of diabetes [I, 216], had recently lost weight [II, 406] and had consulted Dr. Maurice H. Rosenfeld [II, 406], who gave the "insured" a general physical examination, checked his heart and listened to his chest [I, 218], put Appellee on notice and it was on inquiry [II, 432] of its general agents [I, 271] in Los Angeles to secure the information from Dr. Rosenfeld which it now claims was withheld from, and misrepresented to, it.

Simultaneously with its inquiry [II, 432] of its general agents to get in touch with Dr. Rosenfeld and without waiting for any reply thereto, Appellee consciously took a chance, because the risk was with reference to an amount less than $15,000.00, and issued the policy in suit knowing the insured had not mentioned Dr. Lisner or furnished Appellee with "full details" as to "why" he consulted the

doctors, "what" the symtoms, findings or results were, or what treatment or advice was given [II, 432].

By furnishing Appellee with Dr. Rosenfeld's name and address and executing the waiver of privilege and authorization for full disclosure, the insured placed at Appellee's disposal the "exact source" of information from which Appellee could have obtained full and complete information on everything it now claims was withheld from, and misrepresented to, it.

It is with poor grace that Appellee, after the death of the insured and the loss has occurred, inequitably, illogically and illegally, in its effort to avoid liability, urges, *in its own complaint,* that the insurance contract is void, and at the same time seeks, and is allowed, to stand on the insured's waiver of privilege and express authorization for full disclosure, a provision expressly made a part of the contract, then being repudiated as void, by Appellee. Cases cited show the law does not sanction or permit such inconsistency. "The insurer may not repudiate the policy, deny all liability, and at the same time be permitted to stand on a provision inserted in the policy for its benefit."

Even if Appellee's position with respect to the insured's waiver of privilege and express authorization for full disclosure were tenable, and under the law it is not, nevertheless, statements and complaints of the *deceased* made *prior* to the date of the application, to his attending physician or anybody else were hearsay as to Appellant. This would apply to all subjective symptoms on which diagnoses were based. Such evidence was clearly hearsay and erroneously admitted over Appellant's timely objections.

There is no evidence in the record with respect to any unfavorable state of the insured's health when the application was approved, the policy was delivered and the first

premium thereon was paid. Appellee's own medical examiner gave the insured a complete physical examination on November 16, 1942, in connection with the insured's execution of "Part II" and, having in mind the fact that the insured was 64 years of age, it was the opinion of said medical examiner that the insured was then in a normal state of good health and an insurable risk.

Conclusion.

It is respectfully submitted, therefore, that the trial court committed errors of law in

1. Denying Appellant's motion to dismiss;

2. Admitting, over Appellant's objection, testimony of insured's attending physicians with respect to the health and physical condition of the insured;

3. Admitting, over Appellant's objection, testimony of witnesses with respect to statements made by the "insured" prior to the date of the application for the policy in suit, which said statements were not part of the *res gestae;*

4. Failing to find that Appellee had waived its right to complain of concealment or fraud alleged or to claim that the insured was not in good health when the application was approved, the policy was delivered and the first premium thereon was paid;

5. Failing to find that Appellee was estopped to deny liability on the ground of fraud or concealment alleged, or to claim the insured was not in good health when the application was approved, the policy was delivered and the first premium thereon was paid;

6. Decreeing rescission and cancellation of the policy for alleged misrepresentation and concealment attributed to the then deceased insured with respect to his health and medical history.

It is respectfully further submited that there is no competent evidence to sustain the trial court's findings of fact and conclusions of law, to which exception is taken in the specification of errors numbers (5) and (6) respectively, *supra;*

There was no fraud, misrepresentation or concealment. Even if there were, and Appellant makes no such concession, Appellee waived its right to complain, and is estopped to deny liability by reason, thereof inasmuch as it was on notice and inquiry but elected to make and made no investigation, and consciously took a chance because the risk was small in its opinion although the exact source of the information, which it claims was withheld from and misrepresented to it, was made available to Appellee at the time "Part II" was signed by the insured.

The insured's statements to his physicians made prior to his execution of "Part II" were privileged and inadmissible in evidence under the insured's waiver of privilege in the policy, which made the waiver a part of the insurance contract if the contract was void as Appellee claimed and in its complaint alleged. Such statements were also hearsay as to Appellant.

Respectfully submitted,

McLaughlin, McGinley & Hanson,
Attorneys for Appellant.

William L. Baugh,
Of Counsel.

APPENDIX.

[Title of District Court and Cause.]

Concise Statement of Points on Appeal Under Rule 19(6).

Notice Is Hereby Given that at the hearing of this appeal, appellants will rely upon the following points:

Point I.

The trial court erred in denying defendants' motion for dismissal at close of plaintiff's case. This error resulted primarily from (a) failure properly to apply the law of contracts which prevents a party from claiming and enjoying the benefits of a contract at the same time while urging the contract to have been void from its inception. The plaintiff had denied liability under the policy of insurance in suit, yet was permitted to claim the benefits of a waiver of confidential communications signed by insured on the application which was made a part of the policy by incorporation; and (b) failure to decree that plaintiff had [74] waived and was estopped to claim that material information had been withheld from it relative to insured's physical condition and medical history.

Point II.

The trial court erred in admitting, over objection of the defendants, testimony of insured's attending physician disclosing information relating to the health and physical condition of the insured during his lifetime. Such information was acquired from insured to enable said attending physician to prescribe treatment. This error was contributed to by the court's failure to rule that (a) a phy-

sician may not, without the consent of his patient, be examined in a civil action as to any information acquired in attending the patient which was necessary to enable him to prescribe or act for the patient; (b) plaintiff insurance company was prohibited and estopped from claiming and enjoying the benefits of the waiver which, by the terms of the policy, was expressly made a part of the contract, when it affirmatively appeared by the pleadings and proof that plaintiff insurance company denied all liability under said policy and claimed that said contract was void from its inception; and (c) certain limited and special waivers signed by the beneficiary under the policy, after the insured's death, did not constitute general waivers of privileged communications relating to the insured's health and medical history.

Point III.

The trial court erred in decreeing rescission and cancellation of the policy in suit for fraud of insured in allegedly concealing and misrepresenting material facts relative to the insured's health and medical history. This error resulted from a failure properly to apply the law of waiver and estoppel against plaintiff insurance company under the special facts shown by the evidence.

Point IV.

The trial court erred in failing to decree that plaintiff [75] had waived the alleged fraud complained of. This error resulted from an improper interpretation and application of the law relating to the defense of waiver in view of the evidence showing that (a) plaintiff insurance com-

pany had placed at its disposal, prior to the issuance of the policy in suit, the exact source from which it could have obtained the information upon which the court decreed rescission and cancellation; (b) plaintiff insurance company was furnished with a waiver of confidential communications, the name of insured's attending physician, the fact of a physical examination shortly prior to the date of the application, yet made no investigation or an incomplete investigation, promptly issued its policy and accepted without protest two annual premiums; and (c) plaintiff insurance company remained silent during the lifetime of insured, and following the death of insured and filing of notice of claim and proof of death, for the first time, by investigation disclosed facts concerning insured's health and medical history, which could have been ascertained by it prior to the issuance of the policy, or, in any event, during the lifetime of insured, by contacting insured's attending physician.

Point V.

The trial court erred in failing to find that plaintiff was estopped from asserting the alleged fraud complained of. The error resulted from an improper interpretation and application of the law relating to the defense of estoppel under the circumstances set forth under Point IV. Additionally, (a) the defendant Harry Lutz had caused to be cancelled, to his prejudice, other insurance policies on the life of the insured, in the belief that the policy in suit was valid; and (b) no attempt was made by plaintiff insurance company to cancel or rescind the policy in suit until after the death of the insured and subsequent to the

time defendant Harry Lutz had materially changed his position [76] by accepting lesser benefits from paid-up policies on the life of insured.

Dated: September 7, 1945.

McLaughlin & McGinley,
John P. McGinley
W. L. Baugh

Attorneys for Appellants Harry Lutz and Harry Lutz and Rose Lutz as Executor and Executrix of the Last Will and Testament of Abe Lutz, Deceased.

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Received copy of the within document this 7th day of Sept. 1945. Meserve, Mumper & Hughes, by Berta Dietrich, Attorneys.

[Endorsed]: Filed Sep. 7, 1945. [77]